

HOW TO APPLY

To apply for health care benefits, complete this application and return it to your local county or tribal agency or complete an application online at access.wi.gov. See below for more information about applying online.

You will need to provide proof of some of your answers. For more information on what you will need to provide, see the Verification Section on page 4.

Call 1-800-362-3002 if you have questions about Medicaid or you need the address and/or telephone number of your local county or tribal agency.

If you need help filling out this application or wish to answer the questions in person or over the telephone, contact your local county or tribal agency. Information is also available online at dhs.wisconsin.gov/medicaid.

If you have a disability and need this information in an alternate format, or if you need it translated to another language, call 1-608-266-3356 (voice) or 1-888-701-1251 (TTY). These services are free of charge.

APPLY ONLINE

ACCESS is an online tool that lets you apply for benefits, check the status of your benefits or report changes to your worker. To visit ACCESS go to access.wi.gov. An online application is the same as a paper application.

HOW TO USE THIS FORM

1. Read the Important Information section and all the instructions before completing the application.
2. Print clearly. Use blue or black ink.
3. Write dates in the MM/DD/YYYY format. (Example: April 2, 1958 would be 04/02/1958.)
4. Enter information about you and/or your spouse.
5. Completely fill out the application. There may be a delay in Medicaid benefits if the application is not complete. (Use the checklist on page 15 to make sure your application is complete.) If your application is not complete, the county or tribal agency will contact you for more information.

Address – Local County or Tribal Agency

[illegible]

IMPORTANT INFORMATION

The following is important information regarding Medicaid for persons who are elderly, blind or have a disability:

Authorized Representative

You may authorize a representative to apply for you. If you want to authorize a representative, fill out the Authorized Representative page (Attachment 2 of this application packet). This will allow that person to complete and sign the application for you. A legal guardian, conservator or power of attorney may apply for an individual without authorization by the individual. If you are a person's court appointed guardian, conservator or have durable power of attorney for finances, you must submit the legal documentation authorizing you to be that person's appointed guardian or durable power of attorney for finances.

Application Date

Your application date is the date the Medicaid office gets your signed application. A decision on your Medicaid will be mailed to you within 30 days of your application date. Unsigned forms will be returned. It is important to apply as soon as possible since the date your benefits will begin, if you are eligible, is based on your application date.

Backdated Coverage

You may be able to get Medicaid benefits for up to three months before your application date if you provide the necessary information to show you met the Medicaid rules for those months. If you want help paying for health care for any of the past three months (backdated coverage) complete the "Medicaid Backdated Coverage Request" page (Attachment 1) found in this application packet.

Personally Identifiable Information / Social Security Number

Personally identifiable information and Social Security Numbers are used only for the direct administration of the Medicaid program.

If someone in your household is not applying for Medicaid, you do not need to provide Social Security Number (SSN) information for that person. Any person who wants Wisconsin Medicaid, but does not provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes § 49.82(2).

If you are applying only for emergency services because of your immigration status, or you are a pregnant woman applying for the BadgerCare Plus Prenatal Services, you do not need to provide SSN information.

Your SSN permits a computer check of your information with government agencies such as the Internal Revenue Service (IRS), Social Security Administration, Department of Revenue and the Department of Workforce Development. In addition, the Department of Health and Family Services will match your name and SSN with information provided by health insurance carriers to determine if you have other health insurance.

Your SSN will not be shared with the United States Citizenship and Immigration Services (USCIS).

Reviews

If you are able to get Medicaid, you will need to complete a review at least once every 12 months to see if you still meet all the Medicaid rules for benefits.

Estate Recovery

If you get Medicaid, Wisconsin State law, with limited exceptions, requires the recovery of certain Medicaid benefits from your estate. The "Estate Recovery Program" brochure (PHC 13032) provides you with information on estate recovery. You may get a copy of the brochure from your local county or tribal agency or by contacting Member Services at 1-800-362-3002. Certain benefits you get in the community after age 55 and all Medicaid benefits you get while residing in a nursing home or while you are an inpatient in a hospital for 30 days or more, are recoverable. Also, if you reside in a nursing home or are institutionalized in a hospital, and are not expected to return home to live, a lien may be placed on your home. A lien may not be placed on your home if you, your spouse or certain other family members reside in the home.

Rights And Responsibilities

Rights

State and Federal laws guarantee rights for members, which include:

- The right to be treated with respect by state and county employees,
- The right to confidentiality of all information given to local county or tribal agencies to determine eligibility. (This does not prohibit the use of such records for program administration.)
- The right of access to local county or tribal agency's records and files relating to your case, except information obtained by the local county or tribal agency under a promise of confidentiality,
- The right to remain eligible for Medicaid benefits even if temporarily absent from the state, if you remain a Wisconsin resident,
- The right to a speedy determination of eligibility status and prior notice of proposed changes in such status,
- The right to emergency medical care,
- The right to request reasonable accommodation to participate in the program for a disability-related reason, or the right to request interpreters or translators to participate in the program, and
- The right to appeal any action taken concerning your Medicaid application or on-going benefits that you do not agree with by requesting a Fair Hearing.

Fair Hearing

You may request a Fair Hearing by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

Or by calling: Telephone (608) 266-3096

The *Request for Fair Hearing* form can also be found on the Division of Hearings and Appeals web site at dha.state.wi.us/home/.

You may also contact the local county or tribal agency where you applied and ask for help filing a Fair Hearing request. Refer to the *Wisconsin Medicaid Program – Enrollment and Benefits* handbook (PHC 10025), or the Notices of Enrollment you will get, to learn more about the fair hearing process. If you are determined eligible for Medicaid, you will get your handbook with your Medicaid *ForwardHealth* card. You can also find the handbook on the Medicaid web site at dhs.wisconsin.gov/em/customerhelp.

If you have any questions about your rights and responsibilities, contact your local county or tribal agency or call Member Services at 1-800-362-3002.

Discrimination

The Department of Health Services (DHS) is an equal opportunity employer and service provider. For civil rights questions, call (608) 266-9372 (voice) or 1-888-701-1251 (TTY).

To file a complaint of discrimination contact either the:

Wisconsin Department of Health Services
Affirmative Action and Civil Rights Compliance Office
1 W. Wilson, Room 555
Madison, WI 53707-7850
Telephone: (608) 266-9372 (voice); (888) 701-1251 (TTY)
Fax: (608) 267-2147

OR

U.S. Department of Health and Human Services
Office for Civil Rights – Region V
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Telephone: (312) 886-5077 (voice) or
(312) 353-5693 (TTY)

Responsibilities

Reporting Changes

Report to the local county or tribal agency **within 10 days**:

- Any changes in **income** of any member of your household, AND
- Any other change in the information you have given on your application that is required to be reported on the Medicaid Change Report form. See the Medicaid Change Report form in this application packet.

Note: If you are in a Medicaid HMO and you move out of state but do not report this move, you will be responsible to repay Wisconsin Medicaid any payment they made to your HMO. For example, if Wisconsin Medicaid paid your HMO \$175 per month for you and your spouse, the amount of overpayment you would have to repay Wisconsin Medicaid is \$350 for each month the HMO was paid after you moved out of state, even if you did not use your Forward card.

Changes can be reported online at access.wi.gov, by calling your worker or you can use the Medicaid Change Report (Attachment 3) in this application packet. **Do not send this form with your application; keep it for future use.**

Verification / Proof

You will need to provide proof of certain information. Some of these include:

Citizenship / Identity

Federal law requires that all U.S. citizens applying for, or getting Medicaid benefits must show proof of their U.S. citizenship and identity. If you are applying for benefits, you will have at least 30 days, from the date of your application, to provide proof to the local county or tribal agency. If you have provided this information in the past, or you receive Medicare, Supplement Security Income or Social Security Disability Income, it may already be on file; your worker will let you know if s/he needs more proof.

We also verify with the U.S. Department of Homeland Security the alien status of all immigrants who apply for benefits for themselves. Immigration status will not be verified with United States Citizenship and Immigration Services (USCIS) for people in your household who are not applying for assistance. If someone in your household is not applying for Medicaid, you do not need to answer this question for that person.

Note: Undocumented immigrants are only eligible for coverage of emergency health care services if they would otherwise be eligible for Medicaid. Pregnant immigrants may be eligible for the BadgerCare Plus Prenatal Services.

Examples of what you can use to prove both citizenship and identity are:

- U.S. Passport
- Certificate of U.S. Citizenship
- Certification of U.S. Naturalization

Examples of what you can use to prove citizenship are:

- U.S. Birth Certificate
- U.S. State Department Report of Birth Abroad
- U.S. Citizen ID card
- Adoption papers showing U.S. birth
- Hospital record of U.S. birth
- U.S. Military Record of Service
- Life or health insurance record showing U.S. birth
- Nursing home admission papers showing U.S. birth

Examples of what you can use to prove identity are:

- State driver license
- ID card issued by federal, state or local government
- School ID card with photo
- U.S. Military Dependent ID card
- U.S. Military ID card or draft record showing U.S. birth
- For children under age 18, a signed Statement of Identity form, HCF10154

Assets

You will be required to provide proof of all your assets. Examples of proof include a copy of your bank statement showing the value of your bank account on the date the application is completed, or something that shows the face value and cash value of your life insurance policy.

Other

Your worker may also ask for proof of the following:

- Medical expenses to meet a deductible,
- Physician's certification (verbally or in writing) that the person is likely to return to the home or apartment within 6 months for institutionalized persons maintaining a home or property and who may be entitled to a home maintenance allowance,
- Documentation for Power of Attorney and Guardianship,
- Disability, and/or
- Pregnancy.

If you have these items available on the day you submit this application, provide a copy of them with your application. You will be contacted by the local local county or tribal agency and be asked to provide proof of missing, conflicting, or vague information, if the information would affect the decision about your Medicaid enrollment.

Do not send original documents in the mail. You may bring in original documents or send photocopies of these items with your application. If you are having trouble getting what you need to provide proof, contact your local county or tribal agency for help.

Race / Ethnicity Codes

Print the code(s) in the space provided that best describes your race/ethnicity.

- I** = **American Indian/Alaskan Native**
- W** = **White** - White, not of Hispanic origin
- P** = **Hawaiian/Other Pacific Islander**
- A** = **Asian** - Japanese, Chinese, Korean, Indian, Pakistani, Sri Lankan, Bangladeshi, Tibetan, Nepali, Bhutan, Afghanistani, Turkestan, Hmong, Lao, Vietnamese, Khmer, Thai, Burmese, Indonesian, Malaysian, Filipino
- B** = **Black/African American**
- H** = **Hispanic or Latino**

WISCONSIN MEDICAID FOR THE ELDERLY / BLIND / DISABLED APPLICATION

Instructions: Before completing this form, read all instructions. Use black or blue ink only. Write all dates in the MM/DD/YYYY format (example: April 2, 1958 would be 04/02/1958). If you need more space to write your answers, please use an additional sheet of paper.

Keep pages 1 through 5 and the Medicaid Change Report (Attachment 3), for future use.

If you are completing this application/review for someone else, complete the Authorization of Representative page (Attachment 2), or attach legal documentation authorizing you to be that person's appointed guardian or durable power of attorney for finances. Information provided on this application should be about the applicant, not the representative.

SECTION I – APPLICANT INFORMATION In this section we need you to tell us about yourself.

Name – Applicant (last, first, MI)

Do you have any names you have previously used such as a married or maiden name? ☐ Yes ☐ No

If yes, what are those names?

Date of birth	Where were you born? (city, state)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number	*Race or Ethnicity	Are you a member, or a child of a member, of a tribe? <input type="checkbox"/> Yes <input type="checkbox"/> No
		In what language do you want your notices printed? <input type="checkbox"/> English <input type="checkbox"/> Spanish
Primary language spoken in your home	Are there any minor children in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No	

*You do not have to answer this question. If you do wish to answer, the codes are on page 5 of the Important Information.

SECTION 2 – CONTACT INFORMATION Please tell us how we can contact you. For telephone numbers, please include the area code.

Name of contact, if not the applicant	
Telephone Number (Applicant) <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	Telephone Number (Authorized Representative / Power of Attorney) <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Other number where we can leave a message	Who does this message number belong to? <input type="checkbox"/> Self <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor <input type="checkbox"/> Relative
Email Address	Who does this email address belong to? <input type="checkbox"/> Self <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor <input type="checkbox"/> Relative

What is the best way to contact you during weekdays?

SECTION 3 – ADDITIONAL APPLICANT INFORMATION

In this section we need additional information about you, the applicant.

Address where you reside ? (If you reside in a medical institution, use the name and address of the institution.)

Street City State Zip Code

Is this also your mailing address? ☐ Yes ☐ No If you answered no, what is your mailing address?

Do you reside in a nursing home, institution for mental disease (IMD), or hospital?

☐ Yes ☐ No

If yes, what is the date you were admitted? _____

Do you intend to continue residing in Wisconsin?

☐ Yes ☐ No

Do you need help paying for health care you received in the last three months? ☐ Yes ☐ No

If you answered yes, complete the Medicaid Backdated Coverage Request form (Attachment 1) in this packet.

Marital status ☐ Single ☐ Married ☐ Legally Separated

☐ Annulled ☐ Divorced ☐ Widowed ☐ Never Married

Are you a U.S. citizen? ☐ Yes ☐ No
(See page 4)

If you are not a U.S. citizen, in what country were you born?

Are you the sponsor of an immigrant?
☐ Yes ☐ No

SECTION 4 – SPOUSE INFORMATION

In this section we will ask you general information about your spouse, if you are married. Answer all questions in this section with your spouse's information. If not married, go to Section 5.

Name (last, first, MI)

Other names previously used such as a maiden or married name.

Spouse's address, if different from applicant's address.

If you are applying for long term care services, do you want your spouse to get the maximum allowed portion of your income? ☐ Yes ☐ No

If no how much would you like your spouse to get? \$ _____

Residing in a nursing home, institution for mental disease (IMD) or hospital? ☐ Yes ☐ No

If you answered yes, stop here and go to Section 5.

Applying for Medicaid?

☐ Yes ☐ No

Race or ethnicity (This question is optional.)

Social Security Number

Are you a member, or a child of a member, of a tribe? ☐ Yes ☐ No

Date of birth

U.S. citizen? ☐ Yes ☐ No

Sponsor of an immigrant? ☐ Yes ☐ No

If not a U.S. citizen, place where born?

SECTION 5 – DISABILITY INFORMATION

Applicant

Have you been determined blind or disabled by the Social Security Administration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you received Supplemental Security Income (SSI) in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you are disabled and not currently working, are you interested in working?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Spouse

Has your spouse been determined blind or disabled by the Social Security Administration?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your spouse received Supplemental Security Income (SSI) in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If your spouse is disabled and not currently working, is s/he interested in working?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 6 – ASSETS

List all assets owned by you and/or your spouse. Include assets owned jointly with any other person. Do not include the value of personal household belongings (televisions, furniture, appliances). Do not list motor vehicle information in this section as we will ask for that in Section 8. Assets include items such as cash, checking or savings accounts, certificates of deposit, trust funds, stocks, bonds, retirement accounts, interest in annuities, U.S. savings bonds, property agreements, contracts for deeds, timeshares, rental property, life estates, livestock, tools, farm machinery, Keogh plans or other tax shelters, personal property being held for investment purposes, etc.

NOTE: You will be asked to provide proof of your assets. See page 5, for more information. Use an additional sheet of paper if more room is needed.

Type of Asset (See Above)	Name of Owner(s)	Current Dollar Amount	Bank / Financial Institution Name and Account Number

SECTION 7 – BURIAL ASSETS

List all burial assets owned by you and/or your spouse. You will be asked to provide proof of your assets. Use an additional sheet of paper if more room is needed.

Type of Burial Asset	Name of Owner(s)	Value
Burial Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No		\$
Irrevocable Burial Trust <input type="checkbox"/> Yes <input type="checkbox"/> No		\$
Other <input type="checkbox"/> Yes <input type="checkbox"/> No		\$

SECTION 8 – VEHICLE INFORMATION

List all motor vehicles owned by you and/or your spouse, if married. Include vehicles owned jointly with another person.

Vehicle 1

Type of vehicle	Year	Make	Model
Amount owed on vehicle \$		Fair Market Value* \$	

Vehicle 2

Type of vehicle	Year	Make	Model
Amount owed on vehicle \$		Fair Market Value* \$	

*By fair market value, we mean the amount that you would get if you sold it on the open market.

SECTION 9 – LIFE INSURANCE

Please tell us about any life insurance you and/or your spouse has.

Do you and/or your spouse have any life insurance policies? ☐ Yes ☐ No

If yes, complete the section below. If no, stop and go to Section 10.

Name of Owner(s)	Cash Value \$	Face Value \$
	\$	\$

SECTION 10 – RESOURCE/INCOME TRANSFER

Please tell us about any income or resources you and/or your spouse have given away or sold for less than fair market value in the last five years. Examples of resources include cash and cash gifts, real estate, stocks or bonds, etc. Use an additional sheet of paper if more room is needed.

Check all that apply. In the last five years, did you and/or your spouse:

- ☐ Yes ☐ No Sell any assets for less than fair market value, (By fair market value, we mean the amount that you would get if you sold it on the open market.)
- ☐ Yes ☐ No Trade assets or income,
- ☐ Yes ☐ No Transfer or give away assets or income,
- ☐ Yes ☐ No Establish or fund a trust,
- ☐ Yes ☐ No Decline or refuse to accept an inheritance, or
- ☐ Yes ☐ No Purchase an annuity, life estate in another person's home, promissory note, loan or mortgage?

If you answered "Yes", to any of the above items fill out the following information. If "No", go to Section 11.

SECTION 10 – RESOURCE/INCOME TRANSFER (Continued)

Asset or Income 1

Type of asset or income	Date given away or sold	Value of asset or income \$
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What did you get in return?

Asset or Income 2

Type of asset or income	Date given away or sold	Value of asset or income \$
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What did you get in return?

SECTION 11 – JOB INCOME AND WAGES

In this section, we need to know about any job income or wages you and/or your spouse receive from employment. List the gross income for each job. By gross, we mean the amount earned before taxes and deductions. Do not list self-employment in this section, we will ask you about self-employment in Section 12.

Job 1

Are you and/or your spouse employed? ☐ Yes ☐ No If yes, answer the following questions. If no, stop here and go to Section 12.

Who has a job? <input type="checkbox"/> You <input type="checkbox"/> Your Spouse	Date employment began
Employer name and address	Gross monthly earnings expected this month \$
	Gross monthly earnings expected next month \$
Hours worked each week?	How much are you paid each hour? \$

How often are you paid?

☐ Each Week ☐ Every Other Week ☐ Twice Each Month ☐ Once Each Month

Are you paid a salary? ☐ Yes ☐ No If "yes", how much are you paid each pay period? \$

Do you get tips or compensation other than your hourly wages or salary? ☐ Yes ☐ No

If "yes", how much do you get each pay period? \$

SECTION 11 – JOB INCOME AND WAGES (Continued)

Job 2

Who has a job? <input type="checkbox"/> You <input type="checkbox"/> Your Spouse	Date employment began
Employer name and address	Gross monthly earnings expected this month \$
	Gross monthly earnings expected next month \$
Hours worked each week?	How much are you paid each hour? \$
How often are you paid? <input type="checkbox"/> Each Week <input type="checkbox"/> Every Other Week <input type="checkbox"/> Twice Each Month <input type="checkbox"/> Once Each Month	
Are you paid a salary? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", how much are you paid each pay period? \$	
Do you get tips or compensation other than your hourly wages or salary? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", how much do you get each pay period? \$	

If you have any other jobs or wages from a job, use a separate sheet of paper and attach it to this application.

SECTION 12 – SELF-EMPLOYMENT

Please tell us about any self-employment income you and/or your spouse receive. You may use an additional sheet of paper if more room is needed.

Self-employment 1

Are you and/or your spouse self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, answer the questions below. List the gross amount reported to the Internal Revenue Service on your tax forms. If no, go to Section 13.	
Who is self-employed? <input type="checkbox"/> You <input type="checkbox"/> Your Spouse	Name and address of this business
Gross annual income \$	Type of business
Gross annual expenses (include amounts claimed for depreciation) \$	

Self-employment 2

Who is self-employed? <input type="checkbox"/> You <input type="checkbox"/> Your Spouse	Name and address of this business
Gross annual income \$	Type of business
Gross annual expenses (include amounts claimed for depreciation) \$	

SECTION 13 – OTHER TYPES OF INCOME

In this section tell us if you and/or your spouse receive any other types of income (other than a current job or self-employment). Examples of other income may include, but are not limited to payments from an annuity or trust, alimony/maintenance, charity, child support, disability/sick pay, interest/dividends, pension/retirement, worker's compensation, money from another person, rental income, Supplemental Security Income (SSI), Social Security, Veterans Benefits, unemployment insurance, etc. List the gross amount, before taxes and deductions.

Type of Income	Who Gets Income	Gross Monthly Amount	Company Name / Address
	<input type="checkbox"/> You <input type="checkbox"/> Spouse	\$	
	<input type="checkbox"/> You <input type="checkbox"/> Spouse	\$	
	<input type="checkbox"/> You <input type="checkbox"/> Spouse	\$	
	<input type="checkbox"/> You <input type="checkbox"/> Spouse	\$	
	<input type="checkbox"/> You <input type="checkbox"/> Spouse	\$	
	<input type="checkbox"/> You <input type="checkbox"/> Spouse	\$	

SECTION 14 – OUT-OF POCKET MEDICAL EXPENSES

List the types of out-of-pocket medical expenses you and/or your spouse have such as co-payments or the cost of over-the-counter drugs. You must indicate if the item is an impairment related work expense. By impairment related work expense we mean any item you or your spouse needs due to your impairment in order to do your job. The expense cannot be one that a similar worker without a disability would have, such as uniforms. Do not list medical insurance premiums or items for which you are reimbursed.

Expense 1

Do you and/or your spouse have any medical expenses? ☐ Yes ☐ No

If yes, complete the information below. If no, stop and go to Section 15.

Type of Medical Expense	Amount of Expense \$	Who has the expense <input type="checkbox"/> You <input type="checkbox"/> Your Spouse	How often paid
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Is this an impairment related work expense? ☐ Yes ☐ No

Expense 2

Type of Medical Expense	Amount of Expense \$	Who has the expense <input type="checkbox"/> You <input type="checkbox"/> Your Spouse	How often paid
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Is this an impairment related work expense? ☐ Yes ☐ No

SECTION 15 – SHELTER / UTILITY COST

In this section, tell us about your household expenses. Some of these may include, but are not limited to mortgage/rent, property taxes, condominium fees, homeowner/renter insurance, water or sewer bills, gas/electric bills, heating cost, etc.

Type of Expense	Who has Expense	Amount of Expense	How Often Paid
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	

SECTION 16 – OTHER ALLOWABLE EXPENSES

In this section, tell us about any other allowable expenses you and/or your spouse have. Allowable expenses may include family support/alimony, court ordered attorney and guardian fees, court ordered child support, and other support obligations.

Who has an Expense	What is the Expense	Amount of Expense	How Often Paid
		\$	
		\$	
		\$	

SECTION 17 – MEDICAL INSURANCE INFORMATION

You must report any third party that may be liable to pay for medical care for you and/or your spouse, including private health insurance, nursing home/long term care insurance, Medicare or Medi-GAP insurance. You must cooperate by giving information as requested. This also includes any insurance that may be available through an employer group health plan or long-term care policy.

Do you and/or your spouse have Medicare Part A or Part B coverage? ☐ Yes ☐ No

Who has the coverage?	Medicare ID Number	Premium Amount	Part A Start Date	Part B Start Date
		\$		
		\$		

Do you and/or your spouse have Medicare Part D coverage? ☐ Yes ☐ No

Who has the coverage?	Name of Plan	Start Date	Monthly Premium Amount
			\$
			\$

SECTION 17 – MEDICAL INSURANCE INFORMATION (Continued)

Do you and/or your spouse have private health or long term care insurance? ☐ Yes ☐ No

Who Is Covered? <input type="checkbox"/> You <input type="checkbox"/> Your Spouse	Date Coverage Began	Premium Amount \$	How Often Paid
Who Pays The Premium? <input type="checkbox"/> You <input type="checkbox"/> Your Spouse	Name of Policyholder	Policy/Insurance Number	
Name and Address of Insurance Company			

If eligible, would you and/or your spouse like the State of Wisconsin to pay your Medicare premiums?

☐ Yes ☐ No

Have you incurred medical bills as a result of an accident or do you have an accident claim pending?

☐ Yes ☐ No If yes, check all that apply. ☐ Incurred Bills ☐ Claim or Settlement Pending

Has your spouse incurred medical bills as a result of an accident or does your spouse have an accident claim pending? ☐ Yes ☐ No

If yes, check all that apply. ☐ Incurred Bills ☐ Claim or Settlement Pending

SECTION 18 - CHECKLIST

Please read and check each off before you mail your application. This could save time in processing your application.

- ☐ Read the Rights and Responsibilities Section.
- ☐ Complete all applicable sections of the application.
- ☐ Enclose with your application any proof, additional documentation or sheets of paper used to complete the application.
- ☐ Include a copy of your immigration status documents, if you are not a U.S. citizen.
- ☐ Complete the Authorized Representative page (Attachment 2) or enclose legal documentation that allows you to be the appointed guardian or durable power of attorney for finances, if you are acting on behalf of an applicant.
- ☐ Enclose the Medicaid Backdated Coverage Request page (Attachment 1), if you are requesting backdated coverage.
- ☐ Keep pages 1 through 5 and the Medicaid Change Report (Attachment 3), for future use.
- ☐ Sign and date the application form.

Send the completed application to your local county or tribal agency. Addresses for local agencies can be found at: dhfs.wisconsin.gov/em/customerhelp or by calling Member Services at 1-800-362-3002.

SECTION 19 - SIGNATURE

Your signature on the application means that you understand and acknowledge that the local county or tribal agency and the Wisconsin Department of Health Services is authorized to request any information that is appropriate and necessary for the proper administration of the Medicaid program authorized under Wisconsin law. Any persons, including financial institutions, credit reporting agencies or educational institutions are authorized to release this information, unless it is prohibited or restricted by law.

Also, your signature on the application means that you understand the questions and statements on this application form and the penalties for giving false information or breaking the rules. By signing the application, you are certifying, under penalty of perjury and false swearing, that all of your answers are correct and complete to the best of your knowledge, including information provided about the immigration and citizenship status of each household member applying for benefits. Also, you understand and agree to provide documents to prove what you have said.

<hr/>	<hr/>
SIGNATURE – Applicant/Representative/Guardian/Power of Attorney/Conservator	Date Signed
<hr/>	<hr/>
SIGNATURE – Applicant/Representative/Guardian/Power of Attorney/Conservator	Date Signed
<hr/>	<hr/>
SIGNATURE – Witness (Needed if signed with an “X” above)	Date Signed
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SIGNATURE – Witness (Needed if signed with an “X” above)	Date Signed

Note: The applicant’s signature must be witnessed by two people if signed with an “X”.

ATTACHMENT 1 - MEDICAID BACKDATED COVERAGE REQUEST

If you are found eligible for Medicaid, you may be able to get Medicaid benefits for up to three months before your application date if all the needed information is collected for the prior months and you are determined to have been eligible in those months. If you want help paying for health care for any of the three months before your application date (backdated coverage), make sure you checked the “Yes” box in Section 3 of the application where this question is asked and complete this form.

If there are any differences in circumstances in any of the three months before your application month list the differences below for each month that you are requesting backdated coverage. Differences may include: address, household composition, vehicles, insurance, income, assets, etc.

What is the date you want eligibility to begin?

Month Prior to Application

Are you requesting backdated coverage for this month? ☐ Yes ☐ No
Is any information included in your application different in this month from the application month?
☐ Yes ☐ No If “Yes”, describe the changes.

Two Months Prior to Application

Are you requesting backdated coverage for this month? ☐ Yes ☐ No
Is any information included in your application different in this month from the application month?
☐ Yes ☐ No If “Yes”, describe the changes.

Three Months Prior to Application

Are you requesting backdated coverage for this month? ☐ Yes ☐ No
Is any information included in your application different in this month from the application month?
☐ Yes ☐ No If “Yes”, describe the changes.

SIGNATURE – Applicant/Representative/Guardian/Power of Attorney/Conservator	Date Signed
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ATTACHMENT 2 - AUTHORIZATION OF REPRESENTATIVE

If you wish to authorize another person to apply for Medicaid, on your behalf, you must complete this section. If you are an Authorized Representative completing the Medicaid application for another person, then you and the applicant must sign the signature section of the Medicaid application. If you are this person's court appointed guardian, conservator or power of attorney for finances, you must submit to the local county or tribal agency the legal documentation authorizing you to apply on behalf of the applicant. You do not need to complete this section.

I authorize _____ (name of representative) to represent me in my application for Medicaid to be filed with the local county or tribal agency administering the program and in the reviews of my eligibility.

I also authorize my representative to provide information and documents which may be necessary to establish my eligibility for Medicaid. I will provide information to my representative that will be true and correct to the best of my knowledge. My representative and I understand that penalties for providing fraudulent information could be a fine of up to \$10,000 and not more than one year in the county jail.

Authorized Representative Information

Name – Authorized Representative (last, first, MI)	Telephone Number (Include Area Code)
Address (Street, City, State, Zip Code)	Email Address

NOTE: Someone other than your representative must witness your signature. Two witness signatures are required if you sign with an "X".

SIGNATURE – Applicant	Date Signed
SIGNATURE – Witness (Required)	Date Signed
SIGNATURE – Witness (Required if signed with an "X" above.)	Date Signed
<input type="checkbox"/> Yes <input type="checkbox"/> No As an authorized representative I understand that I am representing the above named applicant for Medicaid eligibility and that information provided is true and correct to the best of my knowledge.	
SIGNATURE – Authorized Representative	Date Signed

ATTACHMENT 3 - MEDICAID CHANGE REPORT

Do not send with your application. Keep for future use. If you have a change, you can use this form to report changes. You may also report changes online at access.wi.gov or you can contact your worker by telephone or in person. If you report changes using this form, return the completed form to your local county or tribal agency. You can get the address to the local county or tribal agency in the box below, by calling 1-800-362-3002 or at dhs.wisconsin.gov/em/customerhelp.

You must report if anyone moves in or out of your household, if anyone gets married, becomes pregnant, or gives birth to a child, a change in address, income, assets or employment status **within ten days**. If you do not have enough room on this report to document a change, attach a sheet of paper with the additional information written on it to this report.

If you fail to report any changes or provide false information, you may be fined, have to pay back any Medicaid benefits you wrongfully received (even if you did not use your card), be prosecuted or all three. You may be required to provide proof of any changes you report.

(Local County or Tribal Agency)

Personally identifiable information will be used only for the direct administration of the Medicaid program.

Your Name	Case Number	Worker Name
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SECTION 1 - CHANGE IN ADDRESS

If you have moved, you must report your new address.

Date of Change	New Telephone Number		
New Address - Street	City	State	Zip Code

SECTION 2 - CHANGE IN HOUSEHOLD COMPOSITION

You must report if anyone moves in or out of your household, if anyone gets married, becomes pregnant or gives birth to a baby (include information about the person who gave birth and the newborn.)

Name(s) (Last, First, MI)	Date of Change	
Social Security Number (SSN)*	Date of Birth	Relationship to Case Head

Describe the Change

*Providing or applying for an SSN is voluntary; however any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes section 49.82(2).

SECTION 3 - CHANGE IN ASSETS

You must report changes in your household's cash, bank accounts, bonds, stocks or other assets.

Name of Owner (Last, First, MI)	Date of Change	
Type of Asset	Describe the Change	New Value or Amount \$

SECTION 4 – CHANGE IN RESOURCES/INCOME

You must report any income or resources you and/or your spouse have given away or sold for less than fair market value. Examples of resources include cash and cash gifts, real estate, stocks or bonds, an inheritance, etc.

Type of asset or income	Date sold or given away	Value of asset or income \$
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What did you get in return?

SECTION 5 – CHANGE IN VEHICLES

You must report if you obtain, sell or give away a car, truck, motorcycle, boat, snowmobile, camper or another type of vehicle.

Name of Owner(s) (last, first, MI)			Date of Change
Type of Vehicle	Make	Model	Year
Describe Change (bought, sold, etc.)	Amount Received \$	Fair Market Value* \$	Amount Owed? \$

* By fair market value, we mean the amount that you would get if you sold it on the open market.

SECTION 6 - CHANGE IN INCOME

You must report a change in your gross income amount, a new source of income, changes in your employment status (part-time to full-time or full-time to part-time, loss of employment), changes in salary or rate of pay, changes in the amount of Social Security, Veterans benefits, Unemployment Insurance, Worker's Compensation, or any other change in the amount of money your household gets.

Name (Last, First, MI)	Date Income Changed
Source of Income	Monthly Amount \$
How Often Paid <input type="checkbox"/> Each Week <input type="checkbox"/> Every Other Week <input type="checkbox"/> Twice Each Month <input type="checkbox"/> Once Each Month	

SECTION 7 - OTHER CHANGES

You must report any other changes that may affect your Medicaid eligibility. Examples of other changes include someone getting or dropping health insurance, someone becoming disabled or recovering from a disability. A change could also be a change in expenses such as an increase or decrease in health insurance premiums, medical costs or shelter costs.

Describe change	Date of Change
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Do you expect that the changes reported on this form will remain the same next month? ☐ Yes ☐ No

If No, explain.

SECTION 8 – SIGNATURE

- ☐ Yes ☐ No I understand that there are penalties for hiding information or giving false information.
- ☐ Yes ☐ No I understand that I may have to pay back any benefits I receive because I do not fully report changes in my circumstances (even if I do not use my Medicaid card).
- ☐ Yes ☐ No I agree to provide proof of any changes, if asked to do so.
- ☐ Yes ☐ No My answers on this report are correct and complete to the best of my knowledge.

SIGNATURE – Member	Date Signed	Telephone Number
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If this report does not provide enough room to document a change, attach a sheet of paper with the additional information written on it to this report.